



News Flash – The revised *Sole Community Hospital Fact Sheet* (April 2009), which provides information about Sole Community Hospital classification and payments, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/SoleCommHospfctsht508-09.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

MLN Matters® Number: MM6618

Related Change Request (CR) #: 6618

Related CR Release Date: August 28, 2009

Effective Date: October 1, 2009

Related CR Transmittal #: R1809CP

Implementation Date: October 5, 2009

October 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.3

Provider Types Affected

All providers who submit institutional outpatient claims (including non-outpatient prospective payment system (non-OPPS) hospitals) to Medicare Administrative Contractors (MACs), fiscal intermediaries (FIs), or Regional Home Health Intermediaries (RHHIs) for outpatient services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6618, which notifies providers that the I/OCE Specifications Version 10.3 is effective October 1, 2009. Be sure billing staffs are aware of these changes.

Background

CR 6618 describes changes to billing instructions for various payment policies implemented in the October 2009 OPPS update. The October 2009 Integrated Outpatient Code Editor (I/OCE) changes are also discussed in CR 6618. Attached to CR 6618 are lengthy specifications for the I/OCE. A summary of the changes for October 2009 is within Appendix M of Attachment A of CR 6618 and that summary is captured in the following key points.

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Key Points of CR 6618

1. The program will assign Payment Adjustment Flag #4 (Deductible not applicable) to all lines on any OPPS claim where condition code "MA" is present on the claim. This modification is effective January 1, 2003.
2. Modifier 77 will be added to the list of modifiers that will bypass edit 17 – Inappropriate specification of bilateral procedure. This modification is effective January 1, 2003.
3. If code G0379 has been denied or rejected it will not be included in any subsequent special direct admission logic. The default SI (Q3) will be retained as the final SI. An exception is if line item adjustment flag (LIAF) = 1 has been assigned to the line, the denial/rejection will be ignored, the line will be included in subsequent direct admission logic and that logic will determine the final SI). This modification is effective January 1, 2008.
4. STVX/T-packaged codes (Q1, Q2) that are denied or rejected will not be included in any subsequent special packaging logic. The default SI (Q1, Q2) will be retained as the final SI. An exception is if LIAF = 1 has been assigned to the line, the denial/rejection will be ignored, the line will be included in subsequent special packaging logic and that logic will determine the final SI). This modification is effective January 1, 2008.
5. For codes with SI of S, T, V or X that have been denied or rejected, those codes will be ignored in subsequent special S, T, V, X/T logic for packaging Q1 or Q2 codes. An exception is if LIAF = 1 has been assigned to the line, the denial/rejection will be ignored and the line will be included in subsequent logic for packaging the Q1 or Q2 codes. This modification is effective October 1, 2009.
6. For Multiple Imaging composite processing, any independently bilateral composite candidate with modifier 50 will count as 2 units in applying the composite criteria. If any composite Ambulatory Payment Classification (APC) is assigned on an independent or conditional bilateral line with modifier 50 the modifier will be ignored in assigning the discount formula. This modification is effective January 1, 2009.

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7. Any T-packaged (Q/Q2) independent or conditional bilateral code with modifier 50 that is paid separately will have the modifier ignored in assigning the discount formula. This modification is effective January 1, 2008.
8. Any STVX-packaged (Q/Q1) independent or conditional bilateral code with modifier 50 that is paid separately will have the modifier ignored in assigning the discount formula. This modification is effective January 1, 2007.
9. Medicare has made numerous changes to Diagnosis codes, APCs, HCPCS/CPT codes and modifiers. Those changes can be found in Attachment to CR6618 that is titled "Preliminary Summary of Data Changes Integrated OCE v 10.3 Effective October 1, 2009".
10. Version 15.2 of the National Correct Coding Initiatives will be implemented effective with the October 2009 version of the I/OCE.

Additional Information

If you have questions, please contact your Medicare MAC or FI at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the Centers for Medicare & Medicaid Services (CMS) website. The official instruction (CR6618) issued to your Medicare MAC and/or FI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1809CP.pdf> on the CMS website.

CMS also has a web-based training module on the OCE. The module is available at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1 on the Internet.

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